

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

Page: 1 of 3

Investigation ID: 250

License #: 2917-14-001

Organization Name: Three Rivers Treatment Center, LLC

Date of Inspection: 09-18-2024

Program Type/Facility Name: 14-001 Three Rivers Treatment Center

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-46-1070. A. - Any serious incident, accident, or injury to the resident; any overnight absence from the facility without permission; any runaway; and any other unexplained absence shall be reported within 24 hours (i) to the placing agency; (ii) to either the parent or legal guardian, or both as appropriate; and (iii) noted in the resident's record.	NS	Three Rivers Treatment Center This regulation was NOT MET(SYSTEMIC) as evidenced by: The provider failed to report a serious incident to Individual #1's placing agency within 24 hours of its occurrence. After learning about the incident from Individual #1, the placing agency requested the creation of an incident report. The provider created an internal incident report but did not submit it to the Office of Licensing or the Office of Human Rights. Additionally, Individual #1's progress note does not indicate that the serious incident was reported to the placing agency or recorded in Individual #1's records.	PR) 12/03/2024 PR1: The facility incident report was originally dated 09-02-2024 at 1600 and was received by risk management on 09-05-2024 at or about 1000. Individual #1 reported she had been kicked by another individual and wanted to press charges. Facility records indicate that on 09-05-24 the Three Rivers Resident & Family Advocate "contacted Individual #1's DSS worker and DSS is willing to proceed with pressing charges." The facility's investigation initiated on 09-05-2024 revealed that this incident occurred on 09-03-2024, NOT 09-02-2024 as originally reported. There is no record of any progress note for 09-02 or 09-03-24. The date Individual #1 notified the placing agency is unknown. Facility notification to Individual #1's guardian and DSS personnel was 09-05-2024. PR2: Three Rivers will continue to report incidents to guardians and individuals placement agencies on discovery. To facilitate this process, incident reports and resident events are now entered directly into a computerized database by direct care staff and reviewed and distributed as necessary by the Director of Clinical Services. PR3/4: Report distribution will be audited monthly by the Director of Clinical Services. PR5: September 30, 2024. OLR) Accepted 12/04/2024	9/30/2024
12VAC35-46-1070. C. - The provider shall notify the department within 24 hours of any serious illness or injury,	NS	Three Rivers Treatment Center This regulation was NOT MET(SYSTEMIC) as evidenced by:	PR) 12/03/2024 PR1: The facility incident report was originally dated 09-02-2024 at 1600 and was received by risk management on 09-05-2024 at or about	9/30/2024

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

Page: 2 of 3

Investigation ID: 250

License #: 2917-14-001

Organization Name: Three Rivers Treatment Center, LLC

Date of Inspection: 09-18-2024

Program Type/Facility Name: 14-001 Three Rivers Treatment Center

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
any death of a resident, and all other situations as required by the department. Such reports shall include: 1. The date and time the incident occurred; 2. A brief description of the incident; 3. The action taken as a result of the incident; 4. The name of the person who completed the report; 5. The name of the person who made the report to the placing agency and to either the parent or legal guardian; 6. The name of the person to whom the report was made.		The provider failed to notify the Office of Licensing within 24 hours of a serious incident that occurred on September 3, 2024, involving Individual #1. Although the peer-to-peer assault was documented in Individual #1's progress note on September 3, 2024, the provider only created an internal incident report after Individual #1's placing agency requested it on September 5, 2024. This report stated that Individual #1 wished to press charges for the assault. However, the internal incident report incorrectly recorded the peer-to-peer incident as occurring on September 2, 2024, whereas the progress note correctly documented the incident date as September 3, 2024.	1000. Individual #1 reported she had been kicked by another individual and wanted to press charges. Facility records indicate that on 09-05-24 the Three Rivers Resident & Family Advocate "contacted Individual #1's DSS worker and DSS is willing to proceed with pressing charges." The facility's investigation initiated on 09-05-2024 revealed that this incident occurred on 09-03-2024, NOT 09-02-2024 as originally reported. There is no record of any progress note for 09-02 or 09-03-24. The date Individual #1 notified the placing agency is unknown. Facility notification to Individual #1's guardian and DSS personnel was 09-05-2024. Individual #1's clinical record documents a physician visit on 09-04-2024 for "burning epigastric pain" with and order for medication. A progress note created on 09-05-2024 details an incident occurring at 1700 on 09-03-2024, resulting in no injury or physician orders for treatment. This incident did not meet the facility reporting requirements for Office of Licensing notification as a serious incident. Risk Management did not receive any requests from Individual #1 placing agency for the creation of an incident report. When investigation revealed that our original report has been dated incorrectly, a corrected report was distributed. PR2: Three Rivers will continue to report incidents to guardians and individuals placement agencies on discovery. To facilitate this process, incident reports and resident events are now entered directly into a computerized database by direct care staff and reviewed and distributed as necessary by the Director of Clinical Services. Serious incidents will continue to be entered into the CHRIS system for Office of Human Rights and Office of Licensing notifications, and investigative summaries will be forwarded to	

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

Page: 3 of 3

Investigation ID: 250

License #: 2917-14-001

Organization Name: Three Rivers Treatment Center, LLC

Date of Inspection: 09-18-2024

Program Type/Facility Name: 14-001 Three Rivers Treatment Center

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
			individuals guardians and placement agencies through the Director of Clinical Services. PR3/4: Report distribution will be audited monthly by the Director of Clinical Services. PR5: September 30, 2024 OLR) Accepted 12/04/2024	

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Cynthia Gwinn, Licensing Specialist

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined